PRINTED: 12/08/2011 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		085003	B. WING				C <b>2/2011</b>
	PROVIDER OR SUPPLIER	SE	5	STREET ADDRESS, CITY, 4830 KENNETT PIKE WILMINGTON, DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECT RECTIVE ACTION SHOU LENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000 F 241 SS=D	An unannounced a was conducted at the 2011 through Nove deficiencies contain observations, interverse of the facility observations, interverse of the facility observations and review indicated. The facility observed was 43. The twenty eight (28) reads 15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an enhances each restruction of the facility of th	annual and complaint survey his facility from November 14, ember 22, 2011. The ned in this report are based on views, review of resident's of other documentation as ity census the first day of the e Stage II sample totaled	F 00	F Tag 241  A. An audicheck the were been for mea  B. The aboresident eating in Attachm C. Staff will to be aven to eat, eat a table weat a table wea	nodate the resider nent # tinue to be complem of twice weekly evening shifts at a tachment#	all nce and the need residents ho are at ochment# time will nts need. An audit eted a on the meal	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i -	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
AND PLAN O	F CORRECTION		A. BUILDING B. WING		44/99	
		085003		EET ADDRESS, CITY, STATE, ZIP CODE	11/22	/2011
	ROVIDER OR SUPPLIER  IST COUNTRY HOUS	SE	48	330 KENNETT PIKE VILMINGTON, DE 19807		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	)ULD BE	(X5) COMPLETION DATE
F 000			F 000			
F 241 SS=D	was conducted at 2011 through Nove deficiencies contain observations, inter records and review indicated. The facilisurvey was 43. The twenty eight (28) records and review indicated. The facility must purply in an an enhances each records.	annual and complaint survey this facility from November 14, ember 22, 2011. The ned in this report are based on views, review of resident's of other documentation as lity census the first day of the e Stage II sample totaled esidents  Y AND RESPECT OF  romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.	F 241	D. The results of the audit reported at the monthly QI meeting to the DON I January 2012, to ensure compliance.	/quarterly peginning	1/30/2012
	by: Based on observed determined that the promote care for the in a manner and it or enhances each in full recognition include:  During a lunch obtain room on 11/14/11 needed assistance minutes before the There were two of at the same table	ation and interview, it was be facility failed to ensure and two (2) residents (R16 and R36) in an environment that maintains is resident's dignity and respect of their individuality. Findings asservation in the assisted dining is Resident's R16 and R36 ((who with their meals) waited for 30 e staff started to feed them. These 2 other residents were dependently while R16 and R36			,	
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

12/2/1/11

NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST HE PRECEDED BY FILL (REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241 Continued From page 1 This finding was discussed with E2 (DON) and E4 (RN) on 11/22/11.  F 279 SS=E  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced  STREET ADDRESS, CITY, STATE, IP CODE 4830 KENNETT PIKE WILLIAMS WILLIAMS WILLIAMS (WILLIAMS (WI		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
METHODIST COUNTRY HOUSE    METHODIST COUNTRY HOUSE   STREET ADDRESS, CITY, STATE, 2IP CODE 4830 KENNETT PILE 4830 KENNETT PILE 4830 KENNETT PILE (MILMINGTON, DE 19807   PROVIDERS PLANO E CORRECTION (MILD REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLANO E CORRECTION (MILD REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PREFIXENCED TO THE APPROPRIATE   COMPLETION ON TH			085003			l l	· 1
F 241 F 241 Continued From page 1 This finding was discussed with E2 (DON) and E4 (RN) on 11/22/11. F 279 A3.20(d), 493.20(k)(4) DEVELOP SS=E COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocal needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocal well-being as required under §483.25; and any services that would otherwise be required under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R9, R62, R64 and R73) out of 28 sampled residents the facility failed to develop a care plan based on identified care needs. Findings include:  F 241  F 245 F Tag 279 1-Hospice Care Plans A. Resident R73's Hospice care plan was immediately added. Attachment #				48	830 KENNETT PIKE	<del></del>	2,2011
This finding was discussed with E2 (DON) and E4 (RN) on 11/22/11.  F 279 483.20(d), 483.20(k)(1) DEVELOP SS=E  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on record review and interview it was determined that for four (R9, R62, R64 and R73) out of 28 sampled residents the facility failed to develop a care plan based on identified care needs. Findings include:  F 279 F Tag 279 1-Hospice Care Plans  A. Resident R73's Hospice care plan was immediately added. Attachment #	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
services were implemented on 10/15/11.  Although the clinical record contained	F 279	This finding was dia (RN) on 11/22/11. 483.20(d), 483.20(COMPREHENSIVIAL A facility must use to develop, review comprehensive plate of the facility must do plan for each reside objectives and time medical, nursing, a needs that are idented assessment.  The care plan must to be furnished to a highest practicable psychosocial well-§483.25; and any be required under due to the residented sydes. This REQUIREMED by: Based on record to determined that for out of 28 sampled develop a care plan needs. Findings in 1. R73's clinical reservices were imp	k)(1) DEVELOP E CARE PLANS  the results of the assessment and revise the resident's in of care.  evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive  at describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided the right to refuse treatment attain.  INT is not met as evidenced review and interview it was a four (R9, R62, R64 and R73) residents the facility failed to n based on identified care clude:  cord revealed that hospice lemented on 10/15/11.		A. Resident R73's Hosplan was immediate Attachment #	pice care ely added.  is' care for an an.  presence lospice mpleted pice ent #  udit will be  QI meeting ng January	1/30/2012

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	COMPLE	
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F 279	documentation of services, the facicare with measure address the care resident's palliating accordance with wishes, and curred 2:50 PM, E4 ack care plan for R73 2. Cross refer F3 R9 was admitted admission Minimassessment, dat was continent of The quarterly MI R9 was now codincontinent (less incontinence)." Expendings were as Nursing) during 3a. The facility for measurable goal alternative care contracture of the provision of care of motion) abiliting functioning when	involvement of hospice lity failed to develop a plan of able goals and interventions to and treatment related to the we and end-of-life needs, in the assessment, resident's ent standards of practice.  ew with E4 (RN) on 11/18/11 at nowledged the lack of a Hospice 3.		A. A care plan for continuous immediately confor R9. Attachment	inence mpleted # in the ave their tinence their most ence t without a vill have a o address ment # or will ly nent at the ent's MDS . I list any cline as arterly nent or e in	11/23/2011

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 279	services, the facility care with measura address the care a resident's palliative accordance with the wishes, and currer During an interview 2:50 PM, E4 acknoware plan for R73.  2. Cross refer F31 R9 was admitted the admission Minimulassessment, dated was continent of both The quarterly MDS R9 was now code incontinent (less the incontinence)." Decontinence status, care plan to addressing) during an alternative care all contracture of the provision of care, of motion) abilities	reprovivement of hospice of failed to develop a plan of ble goals and interventions to and treatment related to the e and end-of-life needs, in e assessment, resident's at standards of practice.  White with E4 (RN) on 11/18/11 at owledged the lack of a Hospice of the facility on 5/23/11. The m Data Set (MDS) of 6/3/11 stated this resident ladder or coded a "0."  So, dated 9/21/11 revealed that d as "1" or "occasionally nean 7 episodes of spite R9's decline in the facility failed to develop a set this decline.  Inowledged by E2 (Director of a interview on 11/18/11.  The ded to develop a care plan with a land interventions to address and treatment for R 62's ankle and foot joint to ensure prevent decline in ROM (range or improve/maintain the refused to be fitted with an interventions to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to be fitted with an intervention of the refused to the refused to the refused to the refused with an intervention of the refused to	F 279	this report will be reviet the weekly interdiscipl meeting. An audit will completed after seven the meeting to ensure new residents listed or Change in Continence have a continence care place. Attachment #_D. The results of the audit reported at the monthly/quarterly QI to the DON beginning 2012, to ensure comp	linary Il be I days of I that In the Report I plan in I 2 I it will be I meeting January	1/30/2012

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 279	documentation of ir services, the facility care with measurable address the care at resident's palliative accordance with the wishes, and current During an interview 2:50 PM, E4 acknoware plan for R73.  2. Cross refer F315 R9 was admitted to admission Minimum assessment, dated was continent of black the continence of the continence status, care plan to address Findings were acknown and the facility failed measurable goal at alternative care and contracture of the aprovision of care, pof motion) abilities of the continence of the approvision of care, pof motion) abilities of the contracture of the approvision of care, pof motion) abilities of the contracture of the contr	revolvement of hospice of failed to develop a plan of ole goals and interventions to ond treatment related to the and end-of-life needs, in e assessment, resident's it standards of practice.  With E4 (RN) on 11/18/11 at wledged the lack of a Hospice of, example #1 the facility on 5/23/11. The on Data Set (MDS) of/3/11 stated this resident adder or coded a "0."  If dated 9/21/11 revealed that as "1" or "occasionally an 7 episodes of spite R9's decline in the facility failed to develop a set this decline.  If we develop a care plan with a ord interventions to address of treatment for R 62's unkle and foot joint to ensure or improve/maintain erefused to be fitted with an	F 2	Treatment  A. A care pla alternative treatment contractue Attachme  B. All resident who are reinterventite for preserval ternative #	in to address e care and t for R62's res was put in pla nt # / 3 nts with contractu efusing ons were assesse nce of a care plan e care. Attachme of residents with res refusing ons will be review o ensure a care plan the care p	d for ent 12/19/2011.  ved lan 1/25/2012  be ing ary	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		STRUCTION	(X3) DATE S COMPLE	
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(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(l CR	PROVIDER'S PLAN OF CORI EACH CORRECTIVE ACTION S OSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	concern and they vecourse.  PT Progress/Treat stated, "Decline ex do not want them corthotic fitting - Rei PT Progress/Treat stated, "Resident second time with ordischarge from PT Do not recommend severe left ankle in R62 was observed stockings on his let In an interview with 10:30 AM, she ack was not developed alternative interver ROM without the continence and to more sponse to the interview of the interview	Therapy progress realed that foot drop was a vill try to determine best  ment Note dated 6/28/11 rercise, and refuse ankle wt-"I on me". R62 was scheduled for fused Orthotist to fit him ment note dated 7/05/11 attempting to be fitted for rthotist-resident refused - after this time d staff walk resident due to his estability."  I on 11/17/11 wearing a Jobst fit lower extremity.  In E4 (RN) on 11/18/2011 at knowledged that a care plan I to implement appropriate intions related to R62's need for orthotic to provide the needed conitor and evaluate resident's terventions.  In E4 (RO) with bladder included measurable objectives meet this resident's medical is that are identified in the insessment.  Itinence declined from ment (coded 2) on 6/28/11 MDS	F 27	T	A care plan for R62's incontinence was imput in place. Attach #/\(\sigma\) Other residents will latest and most recessores compared for in incontinence. An residents with a decibe care planned. At #/\(\sigma\) The MDS coordinate complete a quarterly continence assessmitime of each residents with a decindicated on the quarterly continence assessmitime of each residents with a decindicated on the quarterly continence assessmitimes of each residents with a decindicated on the quarterly continence assessmitimes of each residents with a decindicated on the quarterly continence assessmitimes of each resident will be residents. Attachment #_/\(\sigma\)	have their ent MDS redecline y cline will tachment or will y ent at the nt's MDS. I list any cline as arterly ent or in) and eviewed at ciplinary will be	11/22/2011
	course.  PT Progress/Treat stated, "Decline ex do not want them conthotic fitting - Rept Progress/Treat stated, "Resident second time with ordischarge from PT Do not recommend severe left ankle in R62 was observed stockings on his lead in an interview with 10:30 AM, she ack was not developed alternative interver ROM without the continence and to more sponse to the interver of the facility failed to care plan for one (incontinence that in and timetables to and nursing needs comprehensive as R62's bladder con "frequently incontinence incontinence incontinentinentinentinentinentinentinentin	ment Note dated 6/28/11 percise, and refuse ankle wt-"I percised Orthotist to fit him ment note dated 7/05/11 percised or refused - after this time at staff walk resident due to his percised by the stability."  I on 11/17/11 wearing a Jobst at lower extremity.  The E4 (RN) on 11/18/2011 at the converse of the stability of the resident and to implement appropriate at the imple			put in place. Attach #/	have their ent MDS r decline y cline will ttachment or will y ent at the nt's MDS. I list any cline as arterly ent or in ) and eviewed at ciplinary will be	11/30/

NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE  STREET ADDRESS, CITY, STATE, ZIP CODE  4830 KENNETT PIKE  WILMINGTON, DE 19807  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE  STREET ADDRESS, CITY, STATE, ZIP CODE  4830 KENNETT PIKE  WILMINGTON, DE 19807  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  4830 KENNETT PIKE  WILMINGTON, DE 19807  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)  COMPLETION DATE						<u> </u>		
METHODIST COUNTRY HOUSE  4830 KENNETT PIKE WILMINGTON, DE 19807  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  4830 KENNETT PIKE WILMINGTON, DE 19807  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION SHOULD BE DEFICIENCY)  COMPLETION DATE			085003	B, Wil	IG		11/22	2/2011
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	PRÉFIX (E	EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
Review of Physical Therapy progress notes/summary revealed that foot drop was a concern and they will try to determine best course.  PT Progress/Treatment Note dated 6/28/11 stated, "Decline exercise, and refuse ankle wt." I do not want them on me". R62 was scheduled for orthotic fitting - Refused Orthotist to fit him PT Progress/Treatment note dated 70/5/11 stated, "Resident attempting to be fitted for second time with orthotist-resident refused discharge from PT after this time Do not recommend staff walk resident due to his severe left ankle instability."  R62 was observed on 11/17/11 wearing a Jobst stockings on his left lower extremity.  In an interview with E4 (RN) on 11/18/2011 at 10:30 AM, she acknowledged that a care plan was not developed to monitor and evaluate resident's response to the interventions.  b. Cross-refer to F315 example 2 The facility failed to develop a comprehensive care plan for one (1) resident (R62) with bladder incontinence that included measurable objectives and timetables to meet this resident's medical and nursing needs that are identified di nthe comprehensive assessment.  R62's bladder continence declined from "frequently incontinent (coded 2) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/11 MDS assessment to "always incontinent" (coded 3) on 8/28/	Revie notes conce cours  PT Pl stated do not orthor PT Pl stated second disch Do not sever R62 stock  In an 10:30 was realtern ROM service responding to and to and recomplishing the service responding to the service responding to the service responding responding to the service responding respond	ew of Physical s/summary revern and they was en and they was en are the difference of the want them obtic fitting - Reformers/Treating and time with on arge from PT of recommending on his left in interview with 0 AM, she ack not developed native intervend without the object and to moonse to the intervend for the intervend on the intervending from the intervending on the intervending the intervending facility failed to plan for one (intimence that intimetables to mursing needs prehensive as its bladder configuently inconting the intervending the	Therapy progress realed that foot drop was a will try to determine best ment Note dated 6/28/11 ercise, and refuse ankle wt-"I me". R62 was scheduled for fused Orthotist to fit him ment note dated 7/05/11 ettempting to be fitted for rithotist-resident refused - after this time if staff walk resident due to his stability."  on 11/17/11 wearing a Jobst if lower extremity.  in E4 (RN) on 11/18/2011 at nowledged that a care plan to implement appropriate intions related to R62's need for rithotic to provide the needed initor and evaluate resident's erventions.  315 example 2 develop a comprehensive 1) resident (R62) with bladder included measurable objectives meet this resident's medical that are identified in the sessment.	F	279	residents with newly identified decline in continence have a concare plan in place.  Attachment #	tinence  t will be  neeting January	1/30/2012

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(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(FACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
his quarterly MDS  This finding was act 11/22/11 at 10:30 / 4. Cross-refer to F. The facility failed to assess factors that injuries and failed to and implement spetthe extent possible reduce her risk for skin tears, cuts, brothers.  483.25 PROVIDE HIGHEST WELL Exact resident must provide the necessor maintain the higmental, and psychaccordance with the and plan of care.  This REQUIREME by: Based on record determined that the one (1) resident (I services to attain well-being in accordance with reservices to attain well-being in accordance assessment. R64 witnessed and/or resulting skin injuries.	cknowledged by E4 (RN) on AM  309 orecognize and failed to the placed R64 at risk for skin to develop a care plan to define edific preventative measures to a to meet R64's needs and sustaining injuries such as uising and abrasions and  CARE/SERVICES FOR BEING  St receive and the facility must sary care and services to attain the physical, nosocial well-being, in the comprehensive assessment  ENT is not met as evidenced review and interview, it was the facility failed to ensure that R64) received the care and the comprehensive had multiple episodes of unwitnessed incidents with ries. Findings include:	F 309	F Tag 279  4-Care Plan for at Risk Skin  A. A care plan to addinat risk for skin tear immediately composition Attachment # 20  B. An assessment for at risk for skin tear completed on all react the Attachment # 20  the At risk for Skin  Assessment Sheet.  Attachment # 20  C. After each skin tear will be reassessed  Risk for Skin Tears sheet and approprinterventions will be place and care plan audit will be done that each resident tear is assessed an planned as needed Attachment # 20  Nurses will be eduthe new forms and	ress R64's s was leted. 2. residents s was esidents. 4. Using Tears 7 a resident using the At Assessment liate be put in lined. An to ensure with a skin d care is cated on lits use.	11/20/2011
Ro4 nad diagnose	SOULOOFD (CHIORIC ODSUBLING		1		ı
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER PROPERTY OR LETTER P	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 his quarterly MDS assessment dated 9/14/11  This finding was acknowledged by E4 (RN) on 11/22/11 at 10:30 AM  4. Cross-refer to F309  The facility failed to recognize and failed to assess factors that placed R64 at risk for skin injuries and failed to develop a care plan to define and implement specific preventative measures to the extent possible to meet R64's needs and reduce her risk for sustaining injuries such as skin tears, cuts, bruising and abrasions and others.  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (1) resident (R64) received the care and services to attain or maintain her highest physical well-being in accordance with the comprehensive assessment. R64 had multiple episodes of witnessed and/or unwitnessed incidents with resulting skin injuries. Findings include:	ROVIDER OR SUPPLIER  SIST COUNTRY HOUSE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 his quarterly MDS assessment dated 9/14/11  This finding was acknowledged by E4 (RN) on 11/22/11 at 10:30 AM  4. 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Findings include:  STREET ADDRESS, CITY, STATE, ZIP CO. 4830 KENNETT PIKE WILLMINGTON, DE 19807  WILMINGTON, DE 19807  F1207  F1279  F12279  F12279  F12279  F12279  F12279  F13279  F1	ROVIDER OR SUPPLIER  18T COUNTRY HOUSE  SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 his quarterly MDS assessment dated 9/14/11  This finding was acknowledged by E4 (RN) on 11/12/2/1 at 10:30 AM  4. Cross-refer to F309 The facility failed to recognize and failed to assess factors that placed R64 at risk for skin injuries and failed to develop a care plan to define and implement specific preventative measures to the extent possible to meet R64's needs and reduce her risk for sustaining injuries such as skin tears, cuts, bruising and abrasions and others.  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and payschosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, it was determined that the facility failed to ensure that one (1) resident (R64) received the care and services to attain or maintain her highest physical, mental, and psychosocial well-being in accordance with the comprehensive assessment. R64 had multiple episodes of witnessed and/or unwitnessed incidents with resulting skin injuries. Findings include:

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I., .	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
AND PLAN C	F CORRECTION		A. BUILDING B. WING		C	3
		085003			11/22	/2011
	ROVIDER OR SUPPLIER DIST COUNTRY HOU	SE	48	EET ADDRESS, CITY, STATE, ZIP CODE 130 KENNETT PIKE 11LMINGTON, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	his quarterly MDS  This finding was a 11/22/11 at 10:30  4. Cross-refer to F The facility failed t assess factors tha injuries and failed and implement sp the extent possible reduce her risk for skin tears, cuts, b others.  483.25 PROVIDE HIGHEST WELL  Each resident mu provide the necessor maintain the himental, and psycli	assessment dated 9/14/11 cknowledged by E4 (RN) on AM 309 o recognize and failed to at placed R64 at risk for skin to develop a care plan to define ecific preventative measures to be to meet R64's needs and a sustaining injuries such as ruising and abrasions and  CARE/SERVICES FOR	F 309	D. The results of the audireported at the monthly/quarterly QI to the DON beginning 2012, to ensure comp	meeting January	1/30/2012
	by: Based on record determined that to one (1) resident ( services to attain well-being in according assessment. R6 witnessed and/or resulting skin inju	ENT is not met as evidenced review and interview, it was he facility failed to ensure that R64) received the care and or maintain her highest physical ordance with the comprehensive 4 had multiple episodes of unwitnessed incidents with tries. Findings include:				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	F CORRECTION	IDENTIFICATION NOTICE	A. BUIL				
		085003	B. WIN	G		11/22	2/2011
	ROVIDER OR SUPPLIER	SE		48	EET ADDRESS, CITY, STATE, ZIP CODE 330 KENNETT PIKE JILMINGTON, DE 19807		·
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	Continued From propulmonary disease unspecified, Chrorodegeneration, (legosteoporosis and laccording to R64's Assessment dated oriented to person wore a hearing aid combative (yelling According to R64's (MDS) assessment 10 (13-15 cognitivity impaired; 0-7 seven independent in all and was not at rist to R64's quarterly 9/22/11, her BIMS decline in her meremained independent in a walker and developing pression R64 was admitted "scab to (L) outer nose; shins econy joint was pink but without socks". A 5/20/11 stated the blood noted to (L) out "Left knee scale to the sock of the s	age 5 age 5 a), anxiety, asthma, debility alic airway obstruction, macular ally blind) osteoarthrosis, hearing loss.  Is nursing Resident Admission Is 5/19/11, she was alert and and place, legally blind and It. She was fearful, tearful, and verbally abusive. Is admission Minimum Data Set at dated 5/31/11, this resident's liew of Mental Status) score was ely intact; 8-12 moderately erely impaired). R64 was Activities of Daily Living (ADLs) k for pressure sores. According MDS assessment dated Is score was 7, indicating a atal status. However, she adent with all ADLs, ambulated remained at no risk for ure sores.  In to the facility on 5/19/11 with wrist and (L) knee; top of her ymotic and bone to great toe resident was wearing shoes diditionally, a nurse's note dated ere was an "open area with fresh knee measuring 1.3 cm x 0.1 abbed area must have reopened dent was unsure of when/how	F3	809	F Tag 309  A. An assessment of Re using the At Risk for Assessment and a recare plan were done immediately. Attack 25 and # 24  B. An assessment for a residents at risk for was completed. Attack 27.  C. After each skin tear will be reassessed used and appropriate into will be put in place a planned. An audit will be put in place a planned. An audit will be one to ensure that resident with a skin assessed and care pineeded. Attachment D. The results of the autreported at the monthly/quarterly of the DON beginning.	skin Tear esulting enment #  c. II skin tears achment # a resident sing the At sessment ervention and care vill be each tear is lanned as at # 28°. adit will be	11/20/2011
	R64's medication	s included Lasix oral tab 60 (20 o PO (by mouth) once a day at na of the lower extremities and			2012, to ensure con	ipliance.	1/30/2012

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C	
		085003	B. WING		į.	2/2011
	ROVIDER OR SUPPLIER	SE	S	STREET ADDRESS, CITY, STATE, ZIP CO 4830 KENNETT PIKE WILMINGTON, DE 19807	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	Prednisone oral tal day for-COPD (chr disease). Review of R64's re was prone to skin	o 5 mg 1 tab by mouth once a onic obstructive pulmonary ecord revealed that this resident tears/bruises/abrasions/other	F 30	09		
	iniuries due to a kr	nown or unknown causes. Aled the following episodes of				
	Resident rang her have a 3 cm skin to Resident said,"I we bathroom and hit is the doorway. Noth doorway." The skin dressing per physological treated with same until the (L) anterior (Interdisciplinary skin tear on 7/29/1/29/1/20/20/20/20/20/20/20/20/20/20/20/20/20/	lated 7/27/11 stated, "At 1445 call light and resident noted to ear to (L) anterior forearm. as in a hurry to get to the my arm on something sharp in ing sharp noted in the n tear was treated with Opsite ician's order and was to be opsite dressing every 3 days or skin tear healed. IDT's feam) review of the resident's 11 revealed that Resident was a toilet using handrails when ed and she slipped into the wall ear.				
	has blood blister to stated" it was due applied opsite to p c. A nurses's not slightlyred".	dated 8/12/11 stated, "Resident o(R) anterior foot. Resident to her shoe being too tight" brevent blister from opening.  es dated 8/31/11stated" Shins	- Land	•		
	see resident's leg	dated 9/11/11 stated, "Called to s,both feet have a +1 ves are warm swollen +2 and red areas presenttender				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		085003	B. WIN	IG		1	2/2011
NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE				483	ET ADDRESS, CITY, STATE, ZIP COE 80 KENNETT PIKE LMINGTON, DE 19807	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	spots on both calv Air pockets noted 9/12/11on palpatic abrasions to the a A nurse's note dat scab on the shin a to right anterior for e. A nurse's note of (5:15 PM) Resider cm x 2cm with slig another resident in space for resident and bandaid appli to areaslight disc f. A nurse's note of cut her right face normal saline. Ap stopped".  g. A nurse's note 0245, this nurse w to assess a bleed assessment a 1.2 noted on the (L) is oozing a moderat Pressure applied she was cleaned (normal saline). I also cleansed wit ointment applied non-adherent dre h. A nurse's note	es extremely painful to touch. over some reddened areas. ons legs are lumpy(L) leg has interior portion". ed 9/13/11 stated, left leg with and pink areas. There is a scab ot.  dated 10/12/11 stated at 1715 int sustained bruise (L) knee 3 int skin tear when bumped by in wheelchair trying to make to pass by, area was cleansed ed10/13/11 "bruising noted comfort upper shin area".  dated 10/19/11stated, "She did while shaving. Cleansed with plied dry dressing until bleeding  dated 11/11/11 stated, "at vas called into Resident's room ing area on her(L) leg. Upon cm x1.1 cm skin tear was ateral calf area. Wound was the amount of bright red blood. to area to stop the bleed then with SAF-clensthen NSS oried blood on rest of the leg was th warm/wet cloth. Bacitracin and area covered with ssing  dated 11/12/11stated, and scant blood noted. Applied		809			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' .	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIDANO	OOMALOTION		A, BUILDING B, WING		1	C 2/2011
NAME OF P	ROVIDER OR SUPPLIER	085003		EET ADDRESS, CITY, STATE, ZIP COD		2/2011
ļ	DIST COUNTRY HOU	SE		30 KENNETT PIKE ILMINGTON, DE 19807		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	still scratches her said I scratched of cleanse the open of for protection.  The facility failed to that placed R64 at to provide service R64's physical nesustaining skin tea other injuries.	ated 11/15/11 stated, "Resident very dry leg and this AM she f a scab from her left calf, area and applied dry dressing o recognize and assess factors risk for skin injuries and failed is to the extent possible to meet eds and reduce her risk for ars, bruising, abrasions and	F 309			
F 315 SS=D	E4(RN) on 11/22/ 483.25(d) NO CA RESTORE BLAD  Based on the resi assessment, the resident who enter indwelling catheter resident's clinical catheterization way who is incontinen treatment and ser infections and to function as possil  This REQUIREM by: Based on observand review of face determined that the resident who was	dent's comprehensive acility must ensure that a are the facility without an er is not catheterized unless the condition demonstrates that as necessary; and a resident tof bladder receives appropriate vices to prevent urinary tract restore as much normal bladder	F 315	A. R9 and R62 were im reassessed (Attachn 29) and a voice started. Attachment Care plans are Attact 30a.  B. All other incontinent will have their Bowe Bladder Training Ass (Attachment # 31 for completion. Usinformation from the assessments, a decimade which resider need a voiding diacare plan completed.	nent # ding diary at #_30 chment # at residents el and sessment audited ng nese sion will be atts will ary and	12/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTR	UCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			C 11/22/2011	
		085003				11/22	12011
NAME OF PROVIDER OR SUPPLIER METHODIST COUNTRY HOUSE				4830 KENNE	SS, CITY, STATE, ZIP CODE IT PIKE ON, DE 19807		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(FAC	ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO B-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	(R9 and R62) out of facility failed to accontinence status a status using a void voiding patterns ar Findings include:  The facility's policy and Bladder Mainte "1. Every resident bladder continence and Bladder Traini resident is incontine or needs incontine measured by the measuring for TEN Residents are put times of before and evening and as neduring the night tin observed on-going determine special individual resident planned. 5. Reside are indicated on the assigned aides level of continence in the resident's to resident and family conference where  1. R9 was admitted diagnoses that incosteomyelitis (inflainfection), polymysmuscles and joints	ler function as possible for two if 28 sampled residents. The urately assess R9's and R62's and failed to evaluate their ing dairy in order to determine id care plan accordingly.  and procedure entitled "Bowel	F 3	C.	New admissions will audited for a complete Bowel and Bladder The Assessment and a total diary completed as a Attachment #	ete Fraining Dileting needed. If be ed to ment nent #	1/25/2012

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ļ · ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 11/22/2011	
IND LINEO			A. BUILDIN			
NAME OF P	ROVIDER OR SUPPLIER	085003		REET ADDRESS, CITY, STATE, ZIP CODE	I IIIZZIZO	<del>'''</del>
METHODIST COUNTRY HOUSE				1830 KENNETT PIKE WILMINGTON, DE 19807		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ONTD BE COM	(X5) IPLETION DATE
F 315	bladder.  The "Resident Adn 5/23/11 checked o and incontinent of additional data dorresident had any fipads. A "Bowel or dated 5/23/11 stated collining and that "most of day" resu (score 0-6: Good of training). There was diary at this time to patterns.  The admission Min assessment, date cognitively intact a of one staff person assessment stated use and was contivus admitted to the 6/30/11. Re-admisincluded orders for (water pill) 20 mg overactive bladded. A quarterly MDS a stated R9 was collimited assistance and toilet use. The stated R9 was oc (less than 7 episorand was not curre scheduled toiletin training) to manage the stated resident resident to manage the stated resident reside	nission Assessment," dated ff that R9 was both continent bladder. There was no cumented, such as whether the requency, dribbling or uses Bladder Training Assessment" ed R9's general health was she was continent of urine liting in a total score equal to "6" candidate for individual as no completion of a voiding of determine R9's voiding of the transfers. This same MDS d R9 was independent for toilet inent of bladder (coded "0"). R9 he hospital from 6/28/11 through sion orders, dated 6/30/11 or daily administration of Lasix and Detrol LA 2 mg (for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ULTIPL LDING	E CONSTRUCTION	COMPLETED		
		085003	B. WIN	IG		11/22	1
NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE				483	ET ADDRESS, CITY, STATE, ZIP CODE 80 KENNETT PIKE LMINGTON, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFIGIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	voiding patterns, faincontinence and so for the incontinence.  A quarterly "Bowel Assessment," com R9 was always co 9/21/11 MDS statistincontinent.  Review of R9's "C (compiled from da Aides) from 6/1/11 following:  - month of 6/11: 11 - month of 7/11: 12 - month of 9/11: 11 - month of 10/11: 12 - month of 10/11: 12 - month of 10/11: 13 - 11/1/11 through incontinence.  On 11/18/11 at 12 an overactive black because she had the bathroom. R9 needed to use an year now.  During an interviee E13 (CNA), she so with R9 since her initially R9 wore bassistance in toile incontinence pad stated that R9 is continence and stated that R9 is continence.	facility failed to assess R9's tiled to identify any patterns of ubsequently failed to care plan		315			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	N OF CORRECTION (IDENTIFICATION NUMBER: A. BUILDING			c		
		085003	B. WING		11/2	2/2011
	ROVIDER OR SUPPLIER	SE		TREET ADDRESS, CITY, STATE, ZIP COD 4830 KENNETT PIKE WILMINGTON, DE 19807	E	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 315	themselves is incopad or brief are for housekeeping staf CNAs do. E13 staf wet pads in R9's transcription. In conclusion, the assess R9's conting a voiding diary to urinary incontinent accordingly. The find who was incontine appropriate treatment normal blad. During an intervie approximately 4:3 findings.  2. R62 was re-add 6/17/11 with diagr status, status pos in Walking, Controparalysis Agitans, joint involving and generalized involved weakness and D disturbances.  According to R62 re-entry assessment.	ntinent she stated that if a wet and in the trash can, f does not empty the trash, the red that she may have found	F 31			
	iii (coded 2 with 7 e	ed as frequently incontinent pisodes or more of urine at least one episode of urine				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085003	B, WING	·		C 11/22/	
	ROVIDER OR SUPPLIER	6E	5	4830	T ADDRESS, CITY, STATE, ZIP CODE D KENNETT PIKE MINGTON, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		(X5) COMPLETION DATE
F 315	continent) of bladd assistance of one of toileting and all oth (ADLs) except eati assessment dated a Toileting Prograr improvement. In an Manager) on 11/18 that there was no tradmission/reentry progression of R62. However, review of documentation of a Assessment Form identify residents were training/maintenthe facility did not R62's incontinence resident was a porput on a toileting pand after meals, to needed to determined per facility's facility's system of toileting times should be a commented to the toileting that daily on the CNAs of R62's CNAs "R revealed the follow continent of bladd Subsequently, accassessment dated	er. R62 needed extensive staff member for transfers and er activities of daily living ng. The re-entry MDS 6/28/11 reflected that a trial of n had been attempted with no n interview with E4 (RN Unit 8/2011 @11:15 AM, she stated rial attempted on for a toileting program due to 2's disease.  If R62's clinical record lacked a completed "Bladder Training " as per facility's system to who are potential candidates for ance of bladder. Additionally, initiate a care plan to address e and /or identified that this ential candidate, that was to be clan for toileting times of before wice in the evening and as ne his special toileting time is procedure. According to the bladder maintenance, these uld be care planned for.  The E4 (RN) on 11/22/11@10:30 adged that the CNAs were the resident was incontinent care tracker. However, review esidentBladder by Shift Chart ving: June 1-30/2011 R62 was er 17 times.	F 3:	15			
	assessment dated	1 9/14/11 R62's cognition had IMS score of 10 out of 15.					

Event ID: JQ8C11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		COMPLETED	
AND PLAN O	- CORRECTION	estable to the control of the contro	A. BUILDING		l l	C	
		085003	B. WING			2/2011	
	ROVIDER OR SUPPLIER	SE	48	ET ADDRESS, CITY, STATE, ZIF 30 KENNETT PIKE ILMINGTON, DE 19807			
(X4) ID PREFIX TAG	/EVOR DEBUTENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 315	9/1/11 thru 9/30/11 continent 9 times. quarterly MDS ass bladder continence incontinent" (code tracker for 10/01/1 documentation that times and the 11/0 continent 9 times.  In an interview with 3:15 PM, she statement of the sta	As bladder care tracker dated revealed that R62 was However, according to his sessment dated 9/14/11, R62's edeclined to "always d3). R62's CNAs bladder care 1 thru 10/30/11 revealed at resident was continent 701/11 - 11/17/11 R62 was the E11 (CNA) on 11/18/2011 at ed that R62 needed 2 staff stance to transfer from bed to d to toilet. R62 did not use the er. She further stated that R62 nile being supported by the staff he staff/bar for support . E11 I that "if I ask him if he wanted to would respond yes and if he he would say no. At times he go and he was always continent					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	FCORRECTION	DEMIII IOMITON MONDERS	A, BUILDIN		С	
		085003			11/22	/2011
	ROVIDER OR SUPPLIER	SE	4	EET ADDRESS, CITY, STATE, ZIP CODE 830 KENNETT PIKE VILMINGTON, DE 19807		
(X4) ID PREFIX TAG	ARACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	QULD BE	(X5) COMPLETION DATE
	Continued From paretraining/maintenain bladder function 483.35(i) FOOD P STORE/PREPARITHE The facility must - (1) Procure food from considered satisfa authorities; and (2) Store, prepare under sanitary conditions and the facility must - (1) Procure food from sanitary conditions authorities; and (2) Store, prepare under sanitary conditions includers and service and	age 15 ance and to prevent a decline to the extent as possible. ROCURE, E/SERVE - SANITARY  om sources approved or ctory by Federal, State or local distribute and serve food aditions  ENT is not met as evidenced ations and interviews, it was ne facility failed to prepare, ve food to residents under s in the kitchen. Findings  the kitchen on 11/14/11 6 (Dietary/Utility Supervisor) and tant and Person-in-Charge of time of the inspection) revealed valk-in refrigerator had no ge. On 11/14/11, an interview onfirmed this finding.	F 371		ge was ents I by the nometer. walk-in udited # dit will be Il meeting g January	1/30/2012
	8:45AM with E7 r towel dispensers hand sinks in the	evealed that two of three paper were empty for the dietary staff kitchen. On 11/14/11, an confirmed this finding.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
•		085003	B. WING		C 11/22/2011	
NAME OF PROVIDER OR SUPPLIER  METHODIST COUNTRY HOUSE			4	REET ADDRESS, CITY, STATE, ZIP CODE 1830 KENNETT PIKE WILMINGTON, DE 19807	11/22/2011	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP	OULD BE COMPLETION	
F 315 F 371 SS=E	retraining/maintenain bladder function 483.35(i) FOOD PI STORE/PREPARE  The facility must - (1) Procure food from from facility must - (1) Procure food from facility from facility food from facility	ance and to prevent a decline to the extent as possible. ROCURE, E/SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food	F 315		ks in the 11/15/2014  Ints by the els. Towels udited 35 . It will be  meeting January 1/30/2012	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	С	
		085003	B. WNG _	1	11/22/2011	
	(EACH DEFICIENC)	CTEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	4	REET ADDRESS, CITY, STATE, ZIP CODE 1830 KENNETT PIKE AVILMINGTON, DE 19807  PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 371	3. Review of Dietar revealed that the fa hired dietary employ horovirus illness, employees from wemployee health for had the Norovirus hired which could be from working with was hired on 1/27/E9 ((Director of CuE10 (Human Reson Specialist)) confirm respectively. 483.35(i)(3) DISPOPROPERLY  The facility must deproperly.  This REQUIREMED by: Based on observed determined that the compactor that was tightly covered to Findings include:  Observations on a compactor area of (Dietary Utility Sul Assistant) revealed to the refuse compactor. Observed fecompactor. Observed fecompactor.	age 16  y Employee health forms acility failed to review if newly oyees (E6 and E7) for the which would prevent orking with food. The dietary orms did not address if the staff illness when they were first have prevented the dietary staff food served to residents. E6 07. E7 was hired on 01/5/11. Illinary & Nutrition Services) and ource/ Business Services hed these findings on 11/22/11  DSE GARBAGE & REFUSE  ENT is not met as evidenced ations and interviews it was he facility failed to keep the has storing garbage and refuse, prevent pest harborage.  11/14/11 at 9:00 AM of the outside the kitchen with E6 pervisor) and E7 (Dietary had that the side door was open pactor and that numerous gnats eding from the garbage on the reations were also made of others on the edge of the door of	F 371	A. The two employees, to a assessed to presence of I symptoms. Attachment 36  B. There were no residents affected by the lack of Not that were identified.  C. The employee health ass form has been replaced form titled "Conditional and Food Employee Internal 27"	identified as orovirus  sessment with a new Employee rview". An audit will on all newly in differ # 38. it will be 1/30/2012 meeting to nuary 2012,	

PRINTED: 12/08/2011 FORM APPROVED OMB NO. 0938-0391

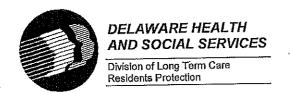
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION  NG	COMPLETED	
		085003	B. WING		11/22/2011	
	ROVIDER OR SUPPLIER		Ì	REET ADDRESS, CITY, STATE, ZIP CODE 4830 KENNETT PIKE WILMINGTON, DE 19807		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 371 F 372 SS=C	3. Review of Dietrevealed that the hired dietary employees from employee health had the Norovirus hired which could from working with was hired on 1/2 E9 ((Director of CE10 (Human Res Specialist)) confirespectively. 483.35(i)(3) DISPROPERLY  The facility must properly.  This REQUIREM by: Based on obserdetermined that compactor that we tightly covered to Findings include.  Observations on compactor area (Dietary Utility S Assistant) reveat to the refuse convere observed frompactor. Observed for compactor.	ary Employee health forms facility failed to review if newly loyees (E6 and E7) for the which would prevent working with food. The dietary forms did not address if the staff is illness when they were first have prevented the dietary staff food served to residents. E6 7/07. E7 was hired on 01/5/11. Culinary & Nutrition Services) and cource/ Business Services med these findings on 11/22/11  POSE GARBAGE & REFUSE  dispose of garbage and refuse  Vations and interviews it was the facility failed to keep the was storing garbage and refuse, o prevent pest harborage.	F 37	F Tag 372 Garbage/Refuse Di	loor was I by the Id be I daily to I door is I tachment I meeting I January	

Event ID: JQ8C11

PRINTED: 12/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	G	С	
		085003	B. WING _		11/22/2011
	ROVIDER OR SUPPLIER	SE.	4	REET ADDRESS, CITY, STATE, ZIP CODE 830 KENNETT PIKE VILMINGTON, DE 19807	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP	OULD BE COMPLETION
F 372	Continued From pa		F 372		
F 456 SS=B	finding. 483.70(c)(2) ESSE OPERATING CON The facility must m mechanical, electric equipment in safe.  This REQUIREME by: Based on an obse was determined the a kitchen dishwash condition. Finding On 11/14/11 at 8:3 kitchen area with E observation of the time revealed a stream of the pipe located dishwasher. The h of about 180 degree potential for injury Wet paper towels of the leaky pipe a unit. In an interview confirmed this find In an interview with	aintain all essential cal, and patient care operating condition.  NT is not met as evidenced evation and staff interviews, it at the facility failed to maintain her in a safe operating include:  O AM, during a tour of the error (Dietary Assistant), an dishwasher in operation at the ream of hot water streaming out in the back, top of the ot water was at a temperature ees Fahrenheit. This caused a to employees due to scalding, were observed around the area nd the front of the dishwasher with E7 on 11/14/11, he ing.  h E9 (Director of Culinary & on 11/14/11 at 11:20 AM, he	F 456	F Tag 456 Kitchen Dishwasher Operation  A. The dishwasher was re Attachment #	epaired 11/14/2011 . eported es her. daily to rr is . lit will be
[					

Facility ID: DE00160



STATE SURVEY REPORT

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NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

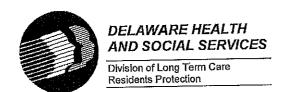
O BE CORRECTED
An audit was initiated to randomly check that residents #R16 & R36 were being fed promptly on arrival for meals. Attachment #  The above audit included all residents needing assistance and eating in the dining room.  Attachment #  Staff will be educated on the need to be available and assist residents to eat, especially those who are at a table with residents who have already been served. Attachment#3 C.N.A. meal time will be adjusted to better accommodate the residents need.  Attachment #
••

Jank Wite

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,

Title Exce Bunk

Date 12/21/1



STATE SURVEY REPORT

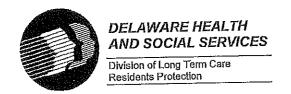
Page 1 of 6

NAME OF FACILITY: Methodist Country Hous	VAME	OF F	FACIL	ITY:	Wethodist	Country	House
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DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED
	Specific Deficiencies	DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report.  An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.  The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents  Skilled and Intermediate Care Nursing Facilities  Scope  Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.  This requirement is not met as evidenced by:	
	Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309	

Provider's Signature full aunt Title Exe Punch Date 1741/1



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report.  An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.  The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents  Skilled and Intermediate Care Nursing Facilities  Scope  Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.  This requirement is not met as evidenced by:  Cross refer to the CMS 2567-L survey report	Report (Attachment #) and this report will
1	date completed 11/22/11, F241, F279, F309,	



STATE SURVEY REPORT

Page 1 of 6

ME OF FACIL	ITY: <u>Methodist Country House</u>	DATE SURVEY COMPLETED: November 22, 2011
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.	be reviewed at the weekly interdisciplinary meeting. An
	An unannounced annual and complaint survey was conducted at this facility from	audit will be completed after seven days of the meeting to

2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty

November 14, 2011 through November 22,

eight (28) residents

Skilled and Intermediate Care Nursing 3201 Facilities

3201.1.0 Scope

3201.1.2

Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309, seven days of the meeting to ensure that new residents listed on the Change in Continence Report have a continence care plan in place. Attachment # 12.

D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

White \_\_\_\_ Title Executive Purch Date \_\_\_

Provider's Signature \_



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

OF DEFICIENCIES WITH ANTICIPATED

DATES TO BE CORRECTED

ADMINISTRATOR'S PLAN FOR CORRECTION STATEMENT OF DEFICIENCIES SECTION Specific Deficiencies The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents Skilled and intermediate Care Nursing 3201 **Facilities** Scope 3201.1.0 Nursing facilities shall be subject to all 3201.1.2 applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred

F Tag 279 3A-Contractures/Refusing Treatment

- A. A care plan to address alternative care and treatment for R62's contractures was put in place. Attachment # 13 .
- B. All residents with contractures who are refusing interventions were assessed for presence of a care plan for alternative care. Attachment # \_\_\_\_\_\_\_
- C. An audit of residents with contractures refusing interventions will be reviewed monthly to ensure a care plan is in place. Attachment # 15.
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

This requirement is not met as evidenced

to, and made part of this Regulation, as if

fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and

incorporated by reference.

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,



STATE SURVEY REPORT

Page 1 of 6

2011.

IE OF FACILITY: Methodist Country House		DATE SURVEY COMPLETED: November 22, 2011	
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.	F Tag 279  3B-Bladder Incontinence Care Plan  A. A care plan for R62's	
	An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22	incontinence was immediately	

The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty

eight (28) residents

Skilled and Intermediate Care Nursing **Facilities** 

3201.1.0 Scope

3201.1.2

3201

Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,

- 16
- B. Other residents will have their latest and most recent MDS scores compared for decline in incontinence. Any residents with a decline will be care planned. Attachment #
- C. The MDS coordinator will complete a quarterly continence assessment at the time of each resident's MDS. The coordinator will list any residents with a decline as indicated on the quarterly continence assessment or MDS on the Change in Continence and this report will be reviewed at the weekly interdisciplinary meeting. An audit will be completed after seven days of the meeting to ensure that



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report.  An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.  The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents  Skilled and Intermediate Care Nursing Facilities  Scope  Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	residents with newly identified decline in continence have a continence care plan in place.  Attachment #/9  D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

Provider's Signature \_

RILIM

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STA
	Sp

STATEMENT OF DEFICIENCIES
Specific Deficiencies

ADMINISTRATOR'S PLAN FOR CORRECTION
OF DEFICIENCIES WITH ANTICIPATED
DATES TO BE CORRECTED

The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.

The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents

3201

Skilled and Intermediate Care Nursing Facilities

3201.1.0

Scope

3201.1.2

Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,

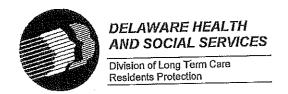
F Tag 279

4-Care Plan for at Risk Skin Tears

- A. A care plan to address R64's at risk for skin tears was immediately completed.

  Attachment # \_\_\_\_\_\_\_.

Provider's Signature Limb Quit Title Carolin Brester Date 12/21/11



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

ADMINISTRATOR'S PLAN FOR CORRECTION STATEMENT OF DEFICIENCIES SECTION OF DEFICIENCIES WITH ANTICIPATED Specific Deficiencies DATES TO BE CORRECTED

The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22,

The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents

3201

Skilled and Intermediate Care Nursing **Facilities** 

3201.1.0

Scope

3201.1.2

Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.

This requirement is not met as evidenced bv.

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,

D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

Title Tree Perente Date 17/21/11



STATE SURVEY REPORT

Page 1 of 6

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.	F Tag 309
	An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.  The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents	A. An assessment of R64 skin using the At Risk for Skin Tear  Assessment and a resulting care plan were done immediately. Attachment #
201	Skilled and Intermediate Care Nursing Facilities	C. After each skin tear a resident will be reassessed using the <u>At</u>

3201.1.0 Scope

3201.1.2

Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,

- Risk for Skin Tear Assessment and appropriate intervention will be put in place and care planned. An audit will be done to ensure that each resident with a skin tear is assessed and care planned as needed. Attachment # 48.
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.



STATE SURVEY REPORT

Page 1 of 6

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report.  An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011.  The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents  Skilled and Intermediate Care Nursing Facilities  Scope  Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	F Tag 315  A. R9 and R62 were immediately reassessed (Attachment #
	This requirement is not met as evidenced by:	

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,



STATE SURVEY REPORT

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NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
1		

F315, F371, F372, and F456.

3201.7.5

Kitchen and Food Storage Areas.
Facilities shall comply with the Delaware
Food Code.

This requirement was not met as evidenced by:

Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-201.11, 4-204.112, 4-501.11, 5-501.15, and 6-301.12 of the State of Delaware Food Code. Findings include:

2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.

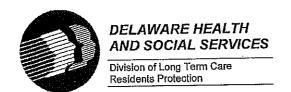
(A) The PERMIT HOLDER shall require FOOD EMPLOYEES and CONDITIONAL EMPLOYEES to report to the PERSON IN CHARGE information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report the information in a manner that allows the PERSON IN CHARGE to reduce the RISK of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE: reportable symptoms (1) Has any of the following symptoms:

- (a) Vomiting,
- (b) Diarrhea,
- (c) Jaundice,
- (d) Sore throat with fever, or
- (e) A lesion containing pus such as a boil

F Tag 371 Norovirus

- A. The two employees, E6 and E7, were assessed to presence of Norovirus symptoms. Attachment #
  - \_36\_\_.
- B. There were no residents identified as affected by the lack of Norovirus that were identified.
- C. The employee health assessment form has been replaced with a new form titled "Conditional Employee and Food Employee Interview".

  Attachment # 37. An audit will be performed monthly on all newly hired dietary to ensure an assessment is completed for Norovirus. Attachment # 38.
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.



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	or infected wound that is open or	
	draining and is:	4
	(i) On the hands or wrists, unless an	
	impermeable cover such as a finger cot	
	or stall protects the lesion and a SINGLE-	
	USE glove is worn over the impermeable	
	cover,	
	(ii) On exposed portions of the arms,	1
	unless the lesion is protected by an	
	impermeable cover, or	
	(iii) On other parts of the body, unless the	
	lesion is covered by a dry, durable, tight- fitting bandage; reportable diagnosis	
	(2) Has an illness diagnosed by a	
	HEALTH PRACTITIONER due to:	} -
	(a) Norovirus,	
	(a) Norovirus, (b) Hepatitis A virus,	
	(c) Shigella spp.,	·
	(d) ENTEROHEMORRHAGIC or SHIGA	
	TOXIN-PRODUCING ESCHERICHIA	
	COLI,P or	
	(e) Salmonella Typhi; reportable past	
	illness	
	(3) Had a previous illness, diagnosed by	
	a HEALTH PRACTITIONER, within the	
	past 3 months due to Salmonella Typhi,	
	without having received antibiotic	·
	therapy, as determined by a HEALTH	·
	PRACTITIONER;P reportable history of	
	exposure	
	(4) Has been exposed to, or is the	
	suspected source of, a CONFIRMED	
	DISEASE OUTBREAK, because the FOOD	
	EMPLOYEE or CONDITIONAL	
	EMPLOYEE consumed or prepared FOOD	
	implicated in the outbreak, or consumed	
	FOOD at an event prepared by a PERSON	
	who is infected or ill with:	
	(a) Norovirus within the past 48 hours of	
	the last exposure,	
	(b) ENTEROHEMORRHAGIC or SHIGA	
	TOXIN-PRODUCING ESCHERICHIA COLI,	
	- a chimally ann within the nact 2 days of	1

or Shigella spp. within the past 3 days of

the last exposure,



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	(c) Salmonella Typhi within the past 14	

days of the last exposure, or
(d) Hepatitis A virus within the past 30
days of the last exposure; or
Reportable history of exposure
(5) Has been exposed by attending or
working in a setting where there is a
CONFIRMED DISEASE OUTBREAK, or
living in the same household as, and has
knowledge about, an individual who
works or attends a setting where there is
a CONFIRMED
(E) A FOOD EMPLOYEE or CONDITIONAL
EMPLOYEE shall report to the

EMPLOYEE shall report to the PERSON IN CHARGE the information as specified under ¶ (A) of this section. responsibility of food employees to comply

(F) A FOOD EMPLOYEE shall:

(1) Comply with an EXCLUSION as specified under

¶¶ 2-201.12(A) - (C) and Subparagraphs 2-201.12(D)(1),(E)(1), (F)(1), or (G)(1) and with the provisions specified under ¶¶ 2-201.13(A) - (G); or

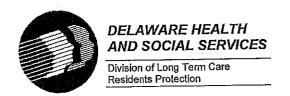
(2) Comply with a RESTRICTION as specified under Subparagraphs 2-201.12(D)(2), (E)(2), (F)(2), (G)(2), or ¶¶ 2-201.12 (H) or (I) and comply with the provisions specified under ¶¶ 2-201.13(D) - (I).

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 3.

4-204.112 Temperature Measuring Devices.

(A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be



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L	

located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

(B) Except as specified in ¶ (C) of this section, cold or hot holding equipment used for potentially hazardous food (time/temperature control for safety food) shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F371, Example 1.

5-205.15 System Maintained in Good Repair.

A PLUMBING SYSTEM shall be:

- (A) Repaired according to LAW; and
- (B) Maintained in good repair.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F456.

5-501.15 Outside Receptacles.

(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

(B) Receptacles and waste handling units

Culinary F371-Sanitary Condition in Kitchen

- A. A thermometer/gauge was placed in the walk-in refrigerator
- There were no residents identified as affected by the absence of the thermometer.
- C. The presence of a thermometer in the walk-in refrigerator will be audited weekly. Attachment #
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.



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located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

(B) Except as specified in ¶ (C) of this section, cold or hot holding equipment used for potentially hazardous food (time/temperature control for safety food) shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F371, Example 1.

5-205.15 System Maintained in Good Repair.

A PLUMBING SYSTEM shall be:

- (A) Repaired according to LAW; and
- (B) Maintained in good repair.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F456.

5-501.15 Outside Receptacles.

(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

(B) Receptacles and waste handling units

F Tag 456 Kitchen Dishwasher Unsafe Operation

- B. There have been no reported incidents of employees involving the dishwasher.
- C. An audit will be done daily to ensure the dishwasher is functioning safely. Attachment #
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.



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for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/22/11, F372.

6-301.12 Hand Drying Provision.
Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:

- (A) Individual, disposable towels;
- (B) A continuous towel system that supplies the user with a clean towel; or
- (C) A heated-air hand drying device; or
- (D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 2.

F Tag 372 Garbage/Refuse Disposal

- A. The compactor side door was cleaned and closed.
- No residents affected by the open compactor could be identified.
- C. An audit will be done daily to ensure the compactor door is clean and closed. Attachment # 39.
- D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.



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	for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.  This requirement was not met as evidenced by:  Cross refer to the CMS 2567-L survey report date completed 11/22/11, F372.  6-301.12 Hand Drying Provision. Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:  (A) Individual, disposable towels; (B) A continuous towel system that supplies the user with a clean towel; or (C) A heated-air hand drying device; or (D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.  This requirement was not met as evidenced by:  Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 2.	F Tag 371 Paper Towels  A. Paper towels were immediately placed in all dispensers at hand sinks in the kitchen.'  B. There were no residents identified as affected by the absence of paper towels.  C. The presence of paper towels at hand sinks will be audited daily. Attachment # 35.  D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.